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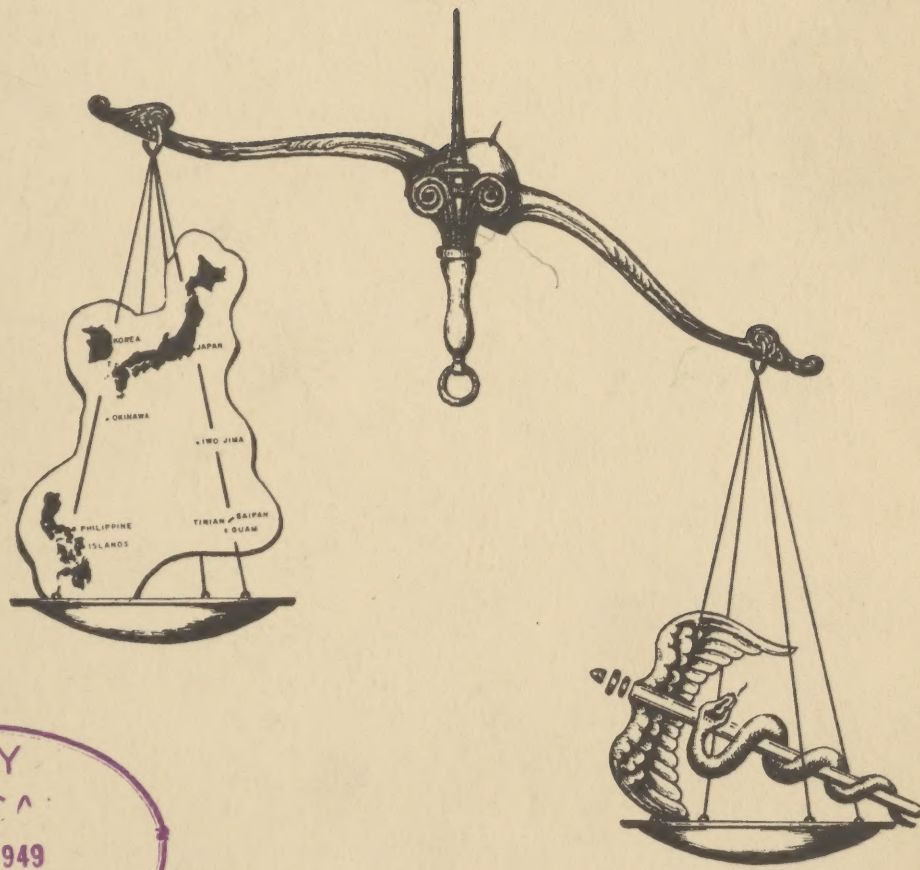
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DOCUMENT SECTION

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VOL IV NO 7
1 JUL 1949



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MEDICAL
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A FAR EAST PERIODICAL OF MEDICAL DEPARTMENT INFORMATION

SURGEON'S CIRCULAR LETTER

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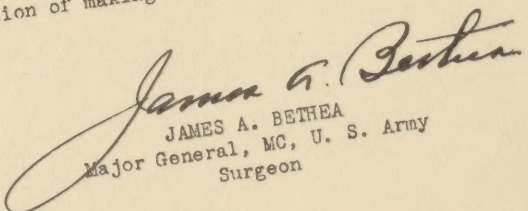
GENERAL HEADQUARTERS
FAR EAST COMMAND
APO 500

TO: All Personnel of the Medical Department, Far East Command

Before departing from this command 11 July 49, I wish to express my appreciation to all members of the Medical Department for their loyal co-operation and support during the past three years.

The splendid health record of the occupation personnel is a testimony to the success of your endeavor. Your devotion to duty and your cheerful acceptance of somewhat trying conditions will always be remembered.

I wish each and every one of you happiness and continued success in your life's mission of making this world a better place in which to live.


JAMES A. BETHEA
Major General, MC, U. S. Army
Surgeon

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GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APC 500

NUMBER. 7

1 July 1949

PART I

ADMINISTRATIVE

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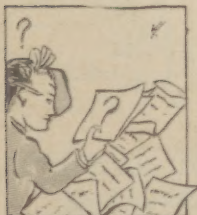
I. Organization of the Medical Section

Arrival in Medical Section. WOJG Ernie L. Barker, formerly with the 35th Station Hospital, has been assigned to the Administrative Division, Medical Section, General Headquarters, Far East Command.

II. Dependents to Accompany Medical Corps and Dental Corps Officers Overseas

Due to the critical shortage of Medical and Dental officers the Department of the Army (Department of the Army (TAG) (AGAO-C) message WCL 47337 dated 10 June 1949) now authorizes coordinated travel of Medical and Dental officers and dependents to all overseas commands and further, that upon request, Medical and Dental officers already in overseas commands without families are to be granted constructive credit under priority system sufficient to qualify for inclusion in the next priority list submitted to The Adjutant General.

III. Quotas Set For Doctors of Medicine and Dentistry



Quotas have been set for each of the forty-eight states in the Armed Forces Emergency Medical - Dental Procurement Program, Secretary of Defense Louis Johnson reported. Requirements range from three each for Nevada and Wyoming, to 716 for New York. Total quota is 3,578. Of this number only 272 have volunteered, leaving 3,306 physicians and dentists still to be procured. Just prior to leaving office, former Secretary of Defense James Forrestal wrote a personal letter to physicians and dentists who received all or part of their professional training at Government expense but who did not take a direct or active part in the war. In the letter he appealed to these men to volunteer for service.

Secretary Johnson stated that many in the above category have not volunteered. He further stated that he had hopes that many of these young professional men would reconsider their decision "in view of their moral obligation to their country." Mr. Johnson asked that physicians and dentists who were deferred during the war, so that they might complete their professional education notify him in writing if and when they would volunteer for active duty.

The need for Medical and Dental Corps officers is still urgent despite procurement efforts.

IV. Medical Personnel Shortage

Major General Raymond W. Bliss, Army Surgeon General, recently advanced one possible solution to alleviate medical personnel shortage in the Army. General Bliss stated that he was seeking part-time volunteer service of medical men and that if 5,000 officers would volunteer their services for an average of three days a month, this would furnish the man-hours in a year equivalent of the services of 600 officers.

He further stated that he was forwarding to 14,300 physicians, 5,548 dentists and 1,372 veterinarians questionnaires asking if they would be available for volunteer duty with the Army for from one to twenty-nine days a month. Those volunteering would be assigned to general and station hospitals in their area.

V. Medical Corps - Voluntary Extensions

In connection with the program to interest Medical Corps officers who are completing category and required service period to extend voluntarily their period of service, a letter was received on 25 April 1949 from the Chief, Personnel Division, Office of the Surgeon General, informing that a policy has been established within that office to permit these officers to be assigned to a specific locality upon their request, provided they agree to extend their tour of service for an additional year.

Due to critical shortage of Medical Corps officers in overseas commands it has been requested that efforts be made to have officers extend in overseas commands or to request a tour overseas. However, if a prospective applicant is not interested in an overseas assignment vacancies also exist in zone of interior station hospitals and non-teaching hospitals. Vacancies in "teaching general hospitals" are practically non-existent and none are anticipated in the near future.

Copies of the letter were dispatched to the Surgeon of each of the Far East Command major commands on 11 May 1949 by letter of transmittal from the Surgeon, Far East Command, containing the information that any such requests be submitted to the Commander-in-Chief, Far East Command, for necessary action.

The letter of transmittal further informed that applicants should recognize that the Surgeon General can not make positive commitments for particular assignments in overseas commands.

There is currently under study in the Far East Command a plan to locally employ a limited number of physicians and dentists in a civilian status from among AUS medical officers upon completion of their current tours of active duty. Further details in connection with this study will be announced at a later date, however, applications for this type duty are currently being honored.

Command surgeons are advised to discuss this with all officers under their jurisdiction who fall within this category.

VI. Establishment of the Medical Services Division

The Office of The Secretary of Defense has issued a memorandum on the establishment of the Medical Services Division. The following directive for the Director of the Medical Services establishes the Medical Services Division within the Office of the Secretary of Defense and describes the authority and responsibilities of the Director of Medical Services.

"DIRECTIVE"FOR DIRECTOR OF MEDICAL SERVICES

"1. Pursuant to the authority vested in me by the National Security Act of 1947 (Public Law 253, 80th Congress) there is hereby established, within the Office of the Secretary of Defense, a Medical Services Division with a Director of Medical Services as the head thereof.

"2. The Director of Medical Services shall be appointed by the Secretary of Defense. He may be a civilian or an officer of one of the armed services.

"3. Under the direction of the Secretary of Defense, he shall have the authority and responsibility for, and shall perform the following duties:

a. Establishment and control of general policies, standards and programs for the medical services of the three military departments and appropriate agencies of the National Military Establishment.

b. Exercise general direction, authority and control over administration and utilization of personnel and facilities of the medical services of such departments and agencies through the heads thereof.

c. Such other duties with respect to the medical services of the National Military Establishment as the Secretary of Defense may direct.

"4. The Secretary of Defense shall provide the Director of Medical Services with such personnel, facilities and other administrative services as the Secretary may determine to be required by the Director for the performance of his functions. Military personnel required shall be furnished by each of the three armed services in approximately equal numbers.

/s/ Louis Johnson

JCS Info Memo 649

Appendix"

VII. National Guard MC Officers to Participate in Army Graduate Study Program

National Guard medical officers will take part in the regular Army's Graduate Professional Education Program under arrangements recently completed with the Surgeon General of the U. S. Army.

The initial quota assigned to the National Guard is ten residencies in orthopedics and three in physical medicine. The courses start on 1 July 1949 and will involve a full year of graduate professional training at Army General Hospitals at full pay and allowances.

Plans are currently under study for expanded participation of National Guard medical officers in the Army program of graduate medical study, which provides approved training in the various fields of medical and surgical specialties.

VIII. Reserve Army Nurse Corps and WMSC on Inactive Status Can Receive Annual Retirement Credits

All qualified graduate nurses of the Army Nurse Corps and those eligible for reserve appointments in the Women's Medical Specialist Corps are urged to make direct application to officer in charge of reserve affairs in their major command.

The requirements for 20-year retirement are as follows:

1. A Reservist must attain the age of 60.
2. Must have completed 20 years of satisfactory active federal service
3. Must meet standards of performance which require her to be active in
4. A Reservist must also hold membership in the Officers Reserve Corps.

as a member of the Reserve.

the Reserve.



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All graduate nurses interested in the Army Nurse Corps Reserve should submit application according to provisions of DA Circular 210, July 1948 and DA Radio 44551, February 1949. (All applications will be processed through The Adjutant General's Office.) Fifty qualifying points are required annually for credit toward 20-year retirement. These points may be earned by:

1. Correspondence courses are available through the Medical Field Service School, Fort Sam Houston, Texas. All correspondence courses should be directed through the local officer in charge of reserve affairs.
2. Attendance at medical meetings and nurses's educational seminars at Army hospitals. Upon satisfactory attendance at these meetings, a certificate will be awarded. The Reserve nurse will receive one copy; two will be forwarded by the certifying officer (the principal chief nurse, or in her absence, the assistant chief nurse) to the officer in charge of reserve affairs; and one will be kept on file in the office of the chief nurse. The number of hours necessary to earn a qualifying point is a minimum of two hours. Not more than one point may be earned daily. Courses conducted by Reserve affairs officers are available to Reserve nurses on inactive duty to earn credit for retirement.
3. "On-the-job" training refresher work is offered in medical and surgical nursing at the local Army hospitals. A maximum of four hours duty is required in either of the above departments. General nursing including new drug therapy and specialized techniques will be included in the period of training. The complete duty uniform of the school, including caps, may be worn. Educational courses as outlined by WD Circular No. 5, dated August 1947, are also available.

All necessary arrangements for this specialized work should be made by contacting the principal chief nurse of the Army hospital in your area, or the officer in charge of reserve affairs.

For determining Reserve retirement credit, the present calendar year is as follows: 29 June 1949 to 28 June 1950. On and after 29 June 1948, a "year" will be computed from 29 June to 28 June, inclusive, of each following year for persons who are members of a reserve component of the Armed services on that date. For persons who entered or reentered the services after 29 June 1949, the "year" will be the annual anniversary of such entry or reentry. Renewal of a commission, warrant, or enlistment will not constitute reentry if reappointment or reenlistment is effective on the day following termination or discharge.

A certificate of satisfactory completion will be awarded applicants who complete the necessary training and may be reproduced locally at each hospital when needed. (FEC AGO Form No. 190, 29 March 49)

IX. Medical Records



Department of the Army Special Regulations 345-920-1, "Records and Reports, Records Administration - Disposition of Records," 15 March 1949, is a consolidated, detailed directive for the maintenance and disposition of records. This regulation is of utmost importance to each medical installation, including laboratories and dispensaries.

The attention of hospital registrars is particularly invited to the new procedure prescribed in chapter 12 for the maintenance and disposition of clinical records. Clinical records closed after 30 April 1949 will be maintained alphabetically on a bimonthly basis, cut off on the last day of each even numbered month, and a new file established on the first day of each odd numbered month. Each bimonthly file will be held six additional months from the closing date of the file and then retired in a group. In accordance with the provisions of Circular 29, GHQ, FEC, 21 August 1948, all records retired by Far East Command installations should be forwarded to Central Records Depot No. 4, Boeki Building No. F 121-1, APO 343, for processing and transshipment to the zone of interior.

X. Control of Mosquito-Borne Diseases - New DA Film

TF 8-1495 "Control of Mosquito-Borne Diseases." (19 minutes - unclassified) Synopsis: A

training film showing how the Army, Navy and Air Forces are constantly cooperating in the control of eradication of Anopheles, Culex and Aedes mosquitoes which are carriers of Malaria, Dengue, Brain Fever and Filariasis diseases. Part of the movie reveals how research personnel, laboratory technicians, doctors and mosquito control teams cooperate with the individual soldier to obtain this end. In the field, control teams are constantly at work eliminating breeding places and destroying the carriers by spraying, but the individual soldier must do his part too, by constantly taking precautionary measures in disease infested areas. The proper use of mosquito netting, protective clothing, repellents and sprays is shown to avoid infection of these mosquito borne diseases.

Use: General Army-wide distribution and for "required" showings in areas where mosquito-borne diseases exist. Related Material: TF 8-953, TF 8-1378, TF 8-2057, Misc. 157, Misc. 1035, Misc. 1046, FB 195, FS 8-64.

XI. Penicillin Storage



Crystalline Penicillin G in oil and wax, as well as straight Crystalline Sodium or Potassium Penicillin G, should be kept at room temperature. Instructions on each package contain the remarks "Do not heat," and "Do not refrigerate."

Recent inspections have shown it still to be the common practice in both dispensary and ward for the penicillin preparations to be stored in the ice box. This results in the P.O.B. becoming so viscous that excessive heating is required to liquefy the preparation.

Commanding officers and chiefs of services should take the necessary steps to discontinue refrigeration of the undiluted penicillin preparations.

XII. Fluorescent Lamps - Warning

A warning against the careless handling of fluorescent lamps has been published by industrial health engineers. Cuts from broken fluorescent lamps may be dangerous, as the tubes are internally coated with a powder called phosphor, which may contain beryllium. If beryllium-covered glass particles get under the skin, the substance may delay the healing of wounds and lead to chronic inflammation and skin lesions.

A recent case of this kind involved a twelve-year-old boy who was cut by an old fluorescent tube that he had been using as a bat. The initial cuts appeared to heal, but eight weeks later painful lumps developed beneath the scars. Three months later these lumps had to be removed by surgery.

It is recommended that great care be taken in handling burned-out fluorescent lamps; discarded tubes should be taken to a waste disposal area and should there be broken. Persons breaking the tubes should wear full protective goggles and should avoid breathing the dust and vapors.

XIII. Medical Department of the Air Force

The establishment of a Medical Department for the Department of the Air Force has been authorized pursuant to authority contained in Joint Army and Air Force Adjustment Regulations No. 1-11-62 dated 16 May 1949. Personnel necessary to meet the requirements of the Air Force Medical Service were authorized to transfer on a voluntary basis from the Department of the Army to the Department of the Air Force. Transfers were to be completed prior to 26 July 1949 on which date enabling legislation expires.

A radiogram from the Department of the Army, prior to receipt of JAAFAR 1-11-62, required that all commanders take immediate action to notify all Medical Department officers (RA, AUS, or civilian components) on active duty of all available details of the new Air Force Medical Department and further required each Medical Department officer to state in an official letter whether he did or did not desire transfer to the Department of the Air Force.

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For general information, the following Army medical installations and activities are those which will be jointly staffed by Army and Air Force medical personnel and will currently provide medical service to the Army and Air Force under provisions of JAAFAR 1-11-62, 16 May 1949:

Named general hospitals.

✓ Army Industrial Hygiene Laboratory.

✓ Army Institute of Pathology.

✓ Army Medical Center.

✓ Army Medical Library.

Central Dental Laboratories.

Medical general laboratories.

Medical general dispensaries.

Recruiting main stations.

Medical Nutrition Laboratory.

Distribution of medical supplies through depots in the United States (by branch medical depots and medical sections of general depots).

Development and computation of supply requirements (as now performed by the Requirements and Stock Control Branch, Supply Division, SGO).

Training pipeline in both military and civilian facilities.

Professors of military science and tactics (at dental, medical veterinary, and pharmacy schools).

XIV. Charges for Medical Care

On center page sheet of this issue is reproduced a chart on medical care charges effective 1 July 1949. Chart is unclassified and may be withdrawn for posting.

XV. Recent Department of the Army and FEC Publications



AR 40-210, C-9, 22 Apr 49. Prevention and Control of Communicable Diseases of Man. Par 10 g (ADMED) Certification of Immunization. Supersedes Sec III, DA Cir 67, 1947.

AR 40-950, 29 Apr 49. Medical Service: Veterinary Meat and Dairy Hygiene - General. These Regulations together with SR 40-950-1, 29 Apr 49, supersede AR 40-2150, 9 Oct 42.

AR 40-1715, C-1, 19 May 49. Blood for Transfusion and Other Purposes.

AR 605-246, 19 May 49. Officers: Retiring Boards. These regulations supersede AR 605-250, 16 Jan 48 and DA Cir 304, 1948.

Catalogs: Army-Navy Catalog of Medical Materiel, Apr 49. Spare Parts Section, 3-095-100. Pamphlet No. 11.

Catalogs: Army-Navy Catalog of Medical Materiel - Standard Price Supplement, July 49 Supersedes supplement dated July 48.

Dept of the Army and the Air Force Bulletin 11, 16 May 49. Transfer Order 36. (Sec II.) Order Transferring From Department of the Army to the Department of the Air Force Certain Functions Relating to the Medical Department, United States Army.

DA Memo 40-590-15, C-1, 25 Apr 49. Report of Treatment of Pay Patients.

GHQ FEC Cir 27, 20 May 49. Personnel Reporting and Accounting. Rescinds Sec II, FEC Cir 80, 1947 and Sec I, FEC Cir 53, 1948; Assignment of Hospital Patients; Transfer of Personnel Upon Completion of Hospitalization.

GHQ FEC Cir 30, 8 June 49. Construction Policy for Japan. Rescinds GHQ FEC Cir 9, 1948, and changes.

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JAAFAR 1-11-62, 16 May 49. Transfer from Department of the Army to Department of the Air Force of Certain Functions Relating to Medical Department, United States Army.

RT 8-75N-26, 29 Apr 49. Armored Medical Battalion (Active Army).

RT 8-77N-20, 29 Apr 49. Company Armored Medical Battalion (Active Army).

SR 310-20-5, 1 Jan 49. Index of Administrative Publications. Sec I - List of Current Regulations and Changes. Sec II - Recissions Supersessions, Etc. Sec III - Alphabetical Index. These regulations supersede AR 1-5, 1 Jan 46 and AR 1-10, 1 July 48, and parts of FM 21-6, 10 Oct 48.

SR 310-20-6, 1 Jan 49. Index to Blank Forms and Military Classification Tests. Supersedes parts of FM 21-6, 1 Oct 48.

SR 40-590-44, 30 March 49. (Corrected Copy). Medical Service: Admission to and Treatment in Medical Facilities of Department of the Army in Continental United States of Members of United States Soldiers Home. Par 6 ac of AR 40-590 Rescinded, Not pars 6 a and 6 c.

SR 40-110-1, 14 Apr 49. Medical Service Standards of Medical Examination for Flying. Supersedes AR 40-110, 12 Dec 44 and C-1, 12 Apr 45.

SR 325-10-1, 19 Apr 49. List of Recurring Reports. Pages 75 - 81, Medical Reports. Rescinds SR 325-10-1, 7 Feb 49.

SR 600-335-10, 27 Apr 49. Personnel: Summary of Changes in Status of General Prisoners Confined in Guardhouses, General Hospitals, and Overseas Installations. Supersedes Par 18 c (1) AR 600-375, and Sec IX, WD Cir 248, 1947.

SR 40-950-1, 29 Apr 49. Medical Service: Veterinary Meat and Dairy Hygiene - General. See reference to AR 40-590, 29 Apr 49.

SR 600-500-5, 29 Apr 49. Personnel: Psychiatric Evaluation Prior to Referral to Boards.

SR 605-60-40, 16 May 49. Officers Medical Service Corps Allied Scientist Procurement - Senior Psychology Student Program.

SR 40-590-11, 18 May 49. Medical Service: Hospital Fund Reports.

SR 40-590-20, 18 May 49. Medical Service: Report of Patients on Seriously Ill List.

SR 40-590-60, 19 May 49. Medical Follow-up Card. (To enable Medical Officers to follow-up clinical course of patients with diseases and/or injuries of unusual professional interest.)

SR 40-590-45, 23 May 49. Medical Service: Admission to and Treatment in Medical Facilities, Department of the Army, of Active, Reserve, and Retired Personnel of Navy and Marine Corps. Supersedes pars 6 g; 11 b (13); 12 a (1)(a) 14, 15, 16, 17 and (b) 3 and 4, AR 40-590, 21 Jan 46.

T/A 10-100-5, 18 March 49. Special Allowances of Quartermaster Expendable Supplies for Medical Units and Installations of United States Army and United States Air Force.

T/O&E 11-15N, 6 Apr 49. Signal Battalion, Corps. Sec III Medical.

T/O&E 19-55, 11 Apr 49. Military Police Battalion. Sec III Medical.

T/O&E 8-317, 12 May 49. Medical Ambulance Company (Separate).

PART II

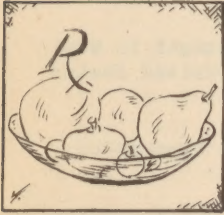
TECHNICAL

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XVII. Low Sodium Diet by Colonel Robert E. Blount, MC, Consultant in Internal Medicine, Medical Section, GHQ, FEC



Low sodium diets are exceedingly useful in the management of edematous states such as may occur in congestive heart failure, nephrosis, the toxemias of pregnancy, and in cirrhosis of the liver with ascites. Many authorities find that the low sodium diet is helpful in arterial hypertension. The common animal protein foods, meat, eggs, milk and cheese have a high sodium content. Consequently maintenance of protein nutrition with sodium restricted diets has been difficult. Use of a low sodium milk (LONALAC, Mead Johnson and Company) combined with limited amounts of meat, eggs and low sodium cereals, vegetables and fats, allows the clinician and dietitian to provide a nutritionally adequate diet containing as little as 200 - 400 mgm of sodium daily. This is in comparison to the average daily dietary intake of about 8 grams of sodium. Lists of the sodium values of foods will be distributed shortly to the chiefs of the medical services of the various hospitals in the Far East Command.

In the preparation of a low sodium diet precautions must be taken to avoid medicinal as well as dietary sources of sodium. Important sources about which the patient must be warned are summarized as follows:

1. Salt, both on the tray and in the preparation of food.

2. Commercially processed foods to which salt has been added, such as smoked, salt cured and processed meats such as ham, bacon, salt pork, salt fish, sausage, corned beef, canned meats and fish, bouillon cubes and meat extracts.

a. Other commercially processed foods which must be avoided are:

- (1) Cheese.
- (2) Olives, pickles, catchup, sauces, salad dressings, prepared mustard, and other pickled and spiced products.
- (3) Canned soups, vegetables, fish and meats.
- (4) Salted fats, including butter and margarine.
- (5) Soda crackers and other ordinary bakery goods.
- (6) Prepared cereals.
- (7) All other foods to which salt has been added, such as salted nuts, popcorn, potato chips, pretzels, and most candy bars and candies.

3. Meat, eggs, milk and cheese, which have a high natural salt content. Eggs and meat may sometimes be taken in limited quantities if milk is replaced by Lonalac.

4. "Soda" products, such as baking powder and baking soda (sodium bicarbonate), and self-rising flours, including biscuit, muffin, pancake and cake mixes; also remedies containing "salts," including the various laxatives.

5. Water with a natural high sodium content (containing in general 3 mg. or more per 100 cc), or water treated by water-softening equipment.

It must be remembered that excessive sodium depletion of the patient is possible.

Therefore the physician must be alert for symptoms of sodium deprivation such as general weakness, exhaustion and abdominal cramps, particularly when sweating is profuse. In patients with impaired renal function the use of a low sodium diet may entail danger.

Paragraph 10 of DA Special Regulation 30-2210-50 dated 11 January 1949 grants authority for the purchase of Special Supplementary Items for use in hospitals. Lonalac is considered as one of these items and can be obtained by special requisition on the local Quartermaster Depot.

XVII. Results of Dental Examination of 15,000 Philippine Scouts November 1948 to April 1949 by Lt. Colonel Stuart M. Mitchell, DC, 10th General Hospital, APO 1105; and Major Bernard H. Bernstein, DC, 8149th Service Unit, APO 900



On November 3, 1948, the 8149th Service Unit, Processing and Training Center, was established to implement the discharge of the Philippine Scouts. As a part of this procedure a Medical Processing Unit was inaugurated to provide physical and dental examination of the Scouts prior to discharge. It was realized that an excellent opportunity presented itself to study the dental health of a large homogeneous group of young adult Filipino males who had been subjected to unusual living conditions in their teens and early twenties. These conditions, of course, were their presence in an active theater of war and subjection to the Japanese occupation of the Islands. The findings in this report were all the more remarkable because of the evident lack of effect of these environmental conditions.

The mean age of Scouts examined was approximately twenty-four years with an average of about three years service. There were however, some older "career" Scouts with twenty to thirty years service. It should be remembered that most of the men reported were young and had been exposed to Army dentistry for three years.

The examination was made by a Dental Officer using a mouth mirror and explorer with good artificial light. The findings were called out to an enlisted technician who then marked the dental chart paragraph 26 of Standard Form 88 accordingly. It is apparent that there were several sources of error. The examiner might call out the wrong numbered tooth, might miss caries or call intact stained teeth as carious. The enlisted man could also mark the chart erroneously. The examination had to be made rapidly but it is believed the errors made were minimal and insufficient to influence the whole picture. One officer and one enlisted man did 90 percent of the examining and charting and became most proficient as a team. The results with explanatory remarks are as follows:

Classification:

Class I - Cases where one or more teeth required extraction.

Class II - Cases where one or more teeth exhibited caries. This was further broken down into (a) cases with multiple caries (b) cases with only one or two caries.

Class III - Cases where there were less than the minimum number of teeth considered necessary to masticate the Army ration or where for esthetic or phonetic reasons replacements were deemed necessary.

Class IV - Cases currently requiring no dental treatment.

The dental classification guided by the above criteria is as follows:

Class I - 372 comprising 2.48% of total.

Class II - 3,719 comprising 24.79% of total.

- a. 1,562 or 42% of Class II had multiple caries.
- b. 2,157 or 58% of Class II had one or two caries.

Class III - 85 comprising 0.57% of total.

Class IV - 10,824 comprising 72.16% of total.

MEDICAL CARE CHARGES EFFECTIVE 1 JULY 1949

(This chart is not intended as an authority for admission to treatment. It is designed to serve as a convenient reference for the medical charges to be assessed persons authorized treatment and commonly present in the FEC. Brief instructions for the collection of charges and disposition of funds have been included. For qualification of persons for treatment, see references cited in column 5. For charges during FY 1949 (1 July 1948 to 30 June 1949) see Cir 16, GHQ, FEC, 1949.)

1	2	3	4	5	6
	CATEGORY OF PATIENTS	FURNISHED TREATMENT UNDER AUTH OF (See Note 6) (See Note 7)	HOSPITALIZA- TION CHARGE PER DIEM	OUTPATIENT CHARGE PER VISIT	COLLECTION & DISPOSITION OF FUNDS (See Notes 8 & 9)
		Per fol par FEC Cir 16, '49:			
1.	NONPAY PATIENTS:				
a.	Enlisted Pers of U. S. Army or Air Force	5a(1)	None	None	Not applicable
b.	TC Civ Marine Pers (Seamen - including officers) of U. S. Army TC vessels (see notes 1 & 2).	5a(2)	"	"	Not applicable
c.	Employees, paid from Army or AF nonappropriated funds, injured in performance of duty (see note 3).	5a(3)	"	"	Not applicable
d.	Prisoners - others in custody or confinement	5a(4)	"	"	Not applicable
e.	Army and Air Force commissioned officers and warrant officers.	5b(1)	\$1.20	"	Collect & de- posit locally
f.	Employees pd fr Army or AF appropd funds & entitled to ret trans. (See Note 1)	5b(2)	\$1.20	"	"
g.	Employees pd fr Army or AF nonappropriated funds & entitled to return trans. This includes PX employees, Service Club hostesses, certain librarians & teachers, & employees of Motion Picture Ser- vice, Central Purchg Office & T&E (AFRS, Stars & Stripes, AEP Instrs)	5b(3)	\$1.20	"	"
h.	Employees of ARC & similar welfare orgns on duty with Armed Forces, other than indigenous pers.	5b(4)	\$1.20	"	"
i.	Retired Army & AF mil pers & retired Navy & Marine Corps officers.	5b(5) & SR 40- 590-45, 23 May 49	\$1.20	"	"
j.	Accredited technical observers, operations analysts & consultants whose duties are as per par 2, FM 30-27.	5b(6)	\$1.20	"	"
k.	Visiting dignitaries individually approved for med care under provs par 6ae, AR 40-590 by either DA or CINCPAC.	Par 6ae, AR 40-590	\$1.20	"	"
l.	Entertainment pers on tour in FEC. This includes USO pers & other authorized entertainment pers.	5b(7)	\$1.20	"	"
m.	Authorized dependents of Army, AF & Navy mil pers.	5c(1) & 5c(2)	\$1.75	"	"
n.	Authd dependents of Army or AF employees entitled to ret trans.	5c(3)	\$1.75	"	"
o.	Authd dependents ARC pers included in category 1h above	5c(4)	\$1.75	"	"
2.	PAY PATIENTS:				
a.	PAY PATIENTS FOR WHOM COLLS ARE MADE BY DA:				Make no colls locally. Rpt direct to SG as rpd par 7e(1) FEC Cir 16, '49
(1)	Beneficiaries of Federal Security Agency, Bureau of Employees' Compensation. (Any Fed employee paid fr appropd funds who con- tracts an injury or disease as a direct result of employment.)	6a(1)(a)	\$10.75	\$1.75	
(2)	Pers of Fed agencies (other than DA & DAF) authd med care at the expense of the agency responsible for them. This category includes:	6a(1)(b)			
(a)	Navy & Marine Corps pers as fols:	SR 40-590-45 23 May 49	\$10.75	None	Make no colls locally. Rpt ea category pa- tients sep. (ex- cept that all PMS beneficiar- ies may be list- ed on same rpt)
1.	Mil pers on active duty.		\$10.60	"	
2.	Ret enl pers & inactive enl pers trfd to Fleet Reserve after 18 or more years sv.		\$10.75	\$1.75	
(b)	Beneficiaries of U.S. Public Health Service as fols:	SR 40-590-42 15 Mar 49	\$10.75	\$1.75	
1.	Officers of PHS on active duty.		\$10.75	\$1.75	
2.	U. S. Coast Guard mil pers.		\$10.75	\$1.75	
3.	U. S. Coast & Geodetic Survey offs & vessel crew members.		\$10.75	\$1.75	
4.	In U. S. & possession only, seamen employed on vessels of U.S.		\$10.75	\$1.75	

c. MISC PAY PATIENTS FOR WHOM COLLS ARE MADE BY GHQ, FEC (See Note 6):				
(1)	In Japan, mil & civ pers of BCOP. This does not include pers of UHLM or other missions.			Rpt to CINCPAC as rqd par 7h, Cir 16, FEC '49
(2)	In Korea, MARBO, PHILCOM & RYCOM, Japanese National crew members of SCAJAP ships (emerg trmt only).			
		6a(2)(g)	\$10.75	\$1.75
		FEC rad ZX 3934, 11 Feb 49		
			\$10.75	\$1.75
				Rpt to CINCPAC as rqd FEC rad ZI 3934, 11 Feb 49
d. MISC PAY PNTS FOR WHOM COLLS ARE MADE BY MED INSTLS CONCERNED. (See Notes 4 & 6)				
(1)	Civ employees of U. S. Fed depts, agencies & commissions (other than DA & DAF) who are not authd med care at public expense. This includes civ employees of State Dept, Commerce Dept, Navy Dept, U.S. Public Roads Adm, U.S. Fish & Wildlife Adm, U.S. Civil Aeronautic Adm, U.S. Weather Bureau, U.S. Veterans Adm, U.S. Reparations & Restitution Del, Foreign Broadcast Infrc Sv, Foreign Liquidations Com, Atomic Bomb Casualty Com, Economic Cooperation Adm and other U.S. fed employees (except DA & DAF) who cannot present an auth for med care at the expense of the Fed Agency responsible for them. (See Note 1)	Per fol par FEC Cir 16, 1949: 6a(2)(b)	\$10.75	\$1.75
				Coll locally & fwd thru Surg, GHQ, per par 7e, Cir 16, FEC '49
(2)	Dependents of Civ employees of U.S. Fed agcy's other than DA & DAF	6a(2)(c)	\$10.75	\$1.75
(3)	Merchant seamen other than those included in cate 1b & 2a(2)(b)4, above.	6a(2)(d)	\$10.75	\$1.75
(4)	Visiting dignitaries & their dependents who are not individually approved for med care under provs par 6a, AR 40-560.	6a(2)(e)	\$10.75	\$1.75
(5)	Members of recognized religious missions who are U.S. citizens.	6a(2)(f)	\$10.75	\$1.75
(6)	In Japan, mil & civ pers of allied or neutral govt agencies & their dependents, except BCOP pers.	6a(2)(g)	\$10.75	\$1.75
(7)	In Japan, Korea, Mariana, Bonin & Ryukyu Islands, authd coml en- trants of U.S., allied & neutral nations, reps of U.S. coml orgns who are U.S. citizens & their dependents. This may inc accredited corpses, traders and reps of coml airlines, oil companies (Petro- leum Advisory Group members), & other business firms such as Philco Radio Corp, Radio Corp of America, Comms Inc, Coca Cola, Pepsi Cola, International Dairy, Coml SS Lines, Etc.	6a(2)(h)	\$10.75	\$1.75
(8)	In Japan, tourists of authd conducted tours.	6a(2)(i)	\$10.75	\$1.75
(9)	Other individuals determined by the maj commander to be in his comd primarily in furtherance of the missions of the CINCPAC.	6a(2)(j)	\$10.75	\$1.75
(10)	Emerg patients not elsewhere classified, furnrd med care to save life or prevent greater suffering.	Par 6ad, AR 40-590	\$10.75	\$1.75

NOTES:

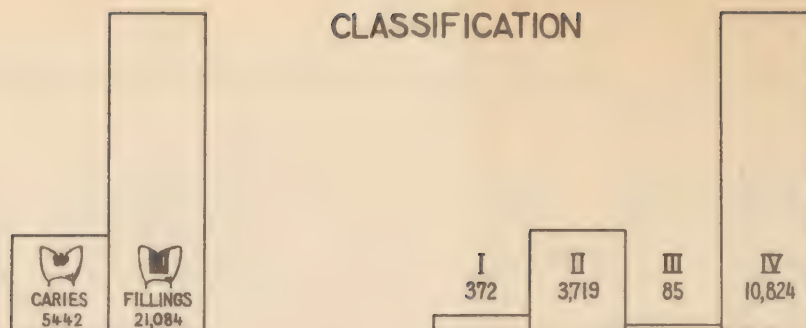
- These persons are eligible for benefits from the Federal Security Agency, Bureau of Employees' Compensation. When injury or disease for which being treated was incurred in the performance of duty or is a direct result of their employment, charges should be billed as provided in category 2a(1), above. See references cited therein and AR 40-560.
- When injury or disease is a result of individual's own misconduct, patient should be treated as a miscellaneous pay patient and charges collected direct from the individual. See par 7e, Cir 16, FEC, 1949.
- Does not apply to enemy nationals.
- With the exception of category 2d(10), it is not intended that indigenous personnel will be included in these categories.
- Unless specifically stated otherwise, all references pertain to paragraphs of Cir 16, GHQ, FEC, 1949.
- In addition to the per diem and per treatment rates stated herein, miscellaneous pay patients will be charged for "un-usual expenses" at actual cost. See paragraphs 7c(3) and 7a(6), Cir 16, GHQ, FEC, 1949.
- The prescribed hospitalization per diem charge will be collected for all hospitalized dependents, except that no charge will be made for a new-born infant patient as long as the mother is also a patient in the hospital. See par 7a(1) and (2), Cir 16, GHQ, FEC, 1949.
- Department of the Army medical installations will forward reports to the Surgeon General, Department of the Army, Attn: Fiscal Division. Department of the Air Force medical installations will forward reports to the Surgeon General, United States Air Force. Channels of submission will be as prescribed for the category of patients covered.
- Delinquent accounts should be forwarded to CINCPAC in accordance with the provisions of par 8, Cir 16, GHQ, FEC, 1949.

The following information was received from Department of the Army in radio WCL 23385, 1 July 49, subsequent to the printing of the chart for medical care charges and should be added thereto as note no. 10:

10. The following additional rates are applicable to pay patients (see par 2 of above chart) effective 1 July 1949:

a. Physical Examination Rate: A rate of \$7.00 is established as the charge for a physical exam, including all necessary procedures and immunizations required in connection with the physical exam, except that physical exams rendered a beneficiary of the civilian components of the Army or Air Force will be at the rate of \$1.75.

b. Immunization Rate: A charge of \$1.00 will be made for each immunization dose or injection, except for those immunizations furnished as an actual part of inpatient treatment (hospitalization), outpatient treatment or a physical examination. In such cases, the applicable rate of \$10.75 per diem for hospitalization, \$1.75 per outpatient visit or \$7.00 per physical exam will be charged.



The totals in Class I and Class III were remarkably low. It became apparent that most of the men in Class I were those who had evaded dental service. These men were afforded the opportunity at time of examination to have further dental service and almost all of them failed to appear. The total in Class III was extremely low because very few Scouts had required multiple extractions and most of those who had multiple extractions presented themselves for denture service.

Class II cases comprising 24.79% of the total was in itself not surprising. The remarkable aspect was that 58% in this class had only one or two caries and were obviously in Class IV at some time. The remaining 42% had three or more caries and were bona fide Class II cases.

A total of 10,824 men of the 15,000 were in Class IV and required no further dental treatment. Of this number 1,868 men had what we call "intact dentition" i.e. all thirty-two teeth present, no caries, no fillings or prosthesis. It must be borne in mind that a large number of men in Class IV also had no fillings but did not have intact dentitions due to the lack of one or two teeth or the presence of a crown. This of course lowered the ratio of "fillings per man."

The number of carious teeth found (5,442) divided by the number of men examined (15,000) gives a figure of .36 caries per man.

The fillings totaled 21,084 or 1.40 fillings per man. As stated above the extraordinarily large number of men who exhibited no fillings bring this figure down. If the number of fillings was divided by the number of men who have received dental service, this figure would be much greater.

The missing teeth totaled 42,315 or an average of 2.82 per man. From these three figures the DMF rate (decayed, missing, filled teeth) for this group of Filipino males was 4.58 per man, average age twenty-four years.

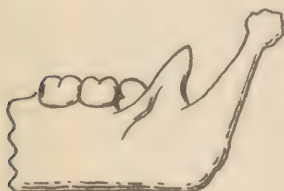


FIG. 1

Only visible impactions were recorded as it was not feasible to radiographically examine each man. The total number of visible impactions was 993. The most common type encountered was where the mandibular third molars were tipped mesially, the dental portion of the crown abutting the second molar (Fig 1). Mandibular impactions predominated and were bilateral in most cases. Mostly non-symptomatic with an occasional pericoronitis.

The 15,000 men exhibited 939 bridges. An interesting feature was that most of these bridges, and individual crowns were evidently constructed by civilian Filipino dentists and many had been made for decorative purposes only at the wishes of the patient. The crowns were "fancy" usually being open faced crowns, the open part being in the form of a star or heart (Fig 2). Many bridges were constructed where the pontic was placed in front of a tooth that was in lingual version (Fig 3). Frequently the six upper anterior teeth were crowned apparently for decorative rather than for restorative purposes.



FIG. 2

GOLD CROWN IN FRONT OF
LATERAL INCISOR



FIG. 3

There were 559 partial dentures present, 344 upper and 215 lower. Most of these appeared to be Army dentures and were about equally divided between anterior and posterior.

A total of 62, 40 upper and 22 lower full dentures were seen and were almost in every case in the older "career Scouts." No fully edentulous cases were observed.

Malocclusion was recorded in only 152 cases. It is obvious that only the more extreme cases were counted since time did not allow for thorough studies of occlusion.

Periodontal conditions were practically nil due mostly to the youth of the group and to the better than average oral hygiene practiced by this group. There were 93 cases of gingivitis recorded and only 52 cases of periodontoclasia, again mostly in the older 25 and 30-year men.

One striking peculiarity, rather common in this group, was the presence of great many "geographic markings." These markings on the lingual surfaces of the upper incisors appeared as very fine light brown lines criss-crossing on surface of the enamel. (Fig 4)



FIG. 4

In conclusion it may be stated that the dental health of this group of 15,000 young adult Filipino males was excellent, showing little deleterious effect from the impact of war and Japanese occupation. Large numbers of

men in this group had never required dental treatment of any kind. Another large number had received dental treatment in the Army and were in good dental health. A small number were in need of treatment but had obviously avoided it. The 1,868 "intact dentitions" were amazing as such a condition in an American national of the same age group is most uncommon. No Vincent's stomatitis present and gingivitis minimal. A general observation was that the average individual had had a minimal amount of dental treatment rendered in civilian life and that it consisted primarily of extractions, practically no operative dentistry, but an unusually large amount of prosthesis consisting of anterior bridges, solid and open faced gold shell crowns, many of the latter being for decorative purposes.

DENTAL CLASSIFICATION EXAMINATION 15,000 PHILIPPINE SCOUTS

CLASS I	CLASS II	CLASS III	CLASS IV
372	3,719	85	10,824
Caries _____	5,442	Full Dentures _____	62
Filling _____	21,080	Upper _____	40
Intact Dentition _____	1,868	Lower _____	22
Impactions _____	993	Gingivitis _____	93
Bridges _____	939	Periodontoclasia _____	58
Partial Dentures _____	559	Malocclusion _____	152
Upper _____	344		
Lower _____	215		

XIX. Infectious Diseases of the Central Nervous System



Infectious diseases of the central nervous system occur among Far East Command personnel with sufficient frequency to be of considerable significance. In 1948, there were 107 cases of poliomyelitis with 11 deaths. Of these, 56 cases and 4 deaths were among military personnel. While July, August and September were the months of highest incidence, sporadic infections occurred throughout most of the year. A total of 23 confirmed cases of meningitis were reported, 12 in military and 11 in non-military personnel. Of this total, 8 were meningococcal infections, 9 were reported as due to other bacteria, 2 were considered to be non-bacterial and in 4 the etiology was not specified. Five deaths occurred from this disease.

Japanese B encephalitis was confirmed in 31 instances among Far East Command personnel in 1948, 29 cases occurring in Japan and 2 in Okinawa. Five of these cases were fatal. Of the 31 total cases, 26 cases and 4 deaths occurred among military personnel, including Navy. In addition, infectious encephalitis, etiology undetermined, was reported 31 times during 1948.

From these incidence figures, it is apparent that infections of the central nervous system do not constitute a major cause of illness and death in the Far East Command. However, because of their nature, they do at times assume a significance far out of proportion to their actual incidence and their occurrence in a command or a community frequently leads to considerable apprehension and alarm. For these reasons and in order that factual information may be available concerning the nature and actual extent of occurrence of these diseases, particularly accurate and detailed reporting of each case is highly desirable. In the past, data on these cases have varied considerably with respect to completeness and detail and, at times, repeated requests for more definitive information has been necessary.

In order to simplify the reporting of these cases to the greatest extent consistent with the collection of the necessary data, specific instructions concerning the information desired have been sent to the major commands. These instructions are presented below for the information and guidance of medical officers in their collection and recording of case histories.

Initial radio reports should be dispatched by hospital commanders as soon as it has been determined that a case or suspected case of infectious disease of the central nervous system has been admitted. This report should be addressed to CINCFE, Attn: Surgeon, with information copies to the Surgeon of the major Army and/or Air Force numbered command concerned, to the CO, 406th Medical General Laboratory and to the patient's immediate commanding officer for his unit surgeon, if applicable. To assure clarity, initial radio reports have been divided into nine parts as follows:

- Part 1: Name and age of patient.
- Part 2: Rank and serial number of patient, if applicable.
- Part 3: Organization, station and place of residence of patient, to include APO number. If patient is a dependent, the organization of the patient's principal should be furnished.
- Part 4: Date patient was admitted.
- Part 5: Diagnosis, in accordance with the provisions of SR 40-1025-1. If the diagnosis is suspected only, that fact should be stated.
- Part 6: The pertinent clinical and laboratory data available, including the cardinal symptoms of patient.
- Part 7: The general date of onset of these symptoms.
- Part 8: The possible place of contraction of the disease if other than is indicated by the organization or residence of patient.
- Part 9: The date and type of each immunization received by the patient within four months prior to the onset of the current illness.

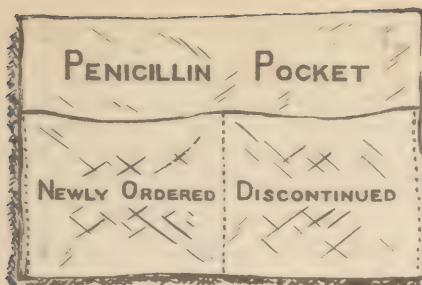
Upon a change in diagnosis or confirmation of a suspected diagnosis, a similar follow-up radio report should be made, giving such additional information as is indicated by laboratory, clinical or epidemiological findings. When final disposition of the patient is accomplished or the patient is evacuated to the zone of interior, a final report should be made giving type of disposition, date of disposition and the final diagnosis of patient.

The above reports are subject to reports control symbol MED-16, which should be cited in each report. They should not be confused with any casualty reports which may be required in addition to these reports.

- XX. Penicillin and Streptomycin Team Established at Army Hospitals by Major Mildred I. Clark, ANC, Chief Nurse, Far East Command (In two parts - Part II - See June 1949 issue, Surgeon's Circular Letter, for Part I this article.)



Prescription forms should be placed in the penicillin pocket on the personnel bulletin board on the ward. This pocket is constructed of X-ray film, 11 inches wide - 7 inches high separated by stitched seams in the center and clearly labeled as follows.



The prescription will be picked up by the technician and the therapy started on the next scheduled round by the team.

In certain cases where immediate therapy is desired, the prescription will be dispatched to central supply by special messenger and the therapy will be started immediately. All other dosage will be started on the hours indicated on the prescription request by the medical officer.

Technique for Administering Therapy: All penicillin dosages should be prepared in central supply service using strict aseptic technique. The hands should be thoroughly washed before the procedure. Enough sterile syringes and needles should be on hand to allow a separate preparation for each dosage. A saturated alcohol sponge should be used to cleanse the top of the penicillin vial. (The dry needle is used to withdraw the fluid out of the vial. An amount of air equal to the amount of solution to be removed should first be drawn into the syringe so that this air may be injected into the vial to replace the fluid that will be withdrawn. This avoids the creation of a partial vacuum within the hermetically sealed bottle.) The puncture in the top of the vial seals itself automatically when the needle is withdrawn.

All syringes containing dosages for the specific hour should be placed by the technician on a sterile field on a tray and dispensed to the wards immediately.

The following items should also be placed on the tray:

1. Sterile syringes with needles containing accurate amount of penicillin as shown in diagram B.
2. A card showing the name of patient, ward number, bed number, and dosage as A.
3. A jar with sterile alcohol sponges as C.
4. A receptacle adjacent to dosages of penicillin for contaminated syringes and needles as D.

Penicillin is usually administered intramuscularly and deep intramuscular injections due to the slow absorption of the drug. The muscles of the arm are used for ordinary intramuscular injections. Deep intramuscular injections are made into the gluteal or lumbar region.

Crystalline penicillin G in oil-beeswax (P.O.B.) is also administered by the team. The preparation (P.O.B.) should be stored at room temperature and should be injected intramuscularly into the upper outer quadrant of alternate buttocks. A separate syringe should be used for each patient in compliance with the provisions of TB MED 78.

The site chosen for injection is first aseptically cleaned with alcohol (70-95%). For ordinary intramuscular injections, the syringe is held at an angle of about 45 degrees while making the injection. The patient should assume one of the following positions for deep intramuscular injections: a prone position, lie on the opposite side to the site of the proposed injection, stand up, sit down, or lean forward over the end of a table. The prone position is considered best, as relaxation of the buttock can be obtained. The size of the needle will depend upon the site of injection. The site of injection should be chosen to avoid any possibility of striking a bone or of depositing irritant material on the periosteum or near the roots of a nerve. Abscess formation and induration may be caused by leakage and deposition of the fluid. To avoid this, great care must be taken. The needle should be thrust into an alcohol-soaked gauze sponge and the syringe carried so

that there is no pressure on the piston. The left hand is placed flat upon the buttocks and with firm pressure the superficial tissue is drawn downward. The needle is then introduced to its full length by a single stroke. The piston must be controlled by pressure of the right thumb against it. The needle must not enter a vein or capillary. If the slightest amount of blood enters the syringe, it should be withdrawn and the procedure repeated one centimeter or more from the site of the first puncture. When it is apparent that no blood can be aspirated, the right hand holding the syringe should maintain the proper angle while the contents are slowly injected with a firm and continuous pressure on the piston.

The flow of the fluid should be free and easy. As the needle is withdrawn by the right hand, the left hand quickly pushes back the tissues to their normal position. The valve-like action thus caused by the slipping back of superficial tissues over the deeper tissue layers considerably reduces the risk of leakage of the fluid into the subcutaneous tissues. Immediately following use, contaminated syringe should be placed in the receptacle of green soap solution.

Precautions to be observed: 1. Be assured that the syringe and needle are sterile and the field has been disinfected.

2. Take every measure to save the patient from pain, remove fears and doubts, and establish confidence.

Recordings: 1. To facilitate safeguarding penicillin and the auditing and inspection of the Register in the hospital, a uniform method of maintaining and recording penicillin administered should be used.

a. The penicillin register will be maintained in a permanently bound ledger - the pages accomplished as shown:

Penicillin Register; Strength 40,000;						64 Station Hospital, APO 6		
Date M/Y	Name of Patient	Time	Amt. Admin. to pt.	24 hr total	Ordered by	Given by	On hand	
26 May 1949	Frank P. Jones	10900	300.00 units	240.000	Capt. Smith	Med. Mary Stans	600,000 units	
27 May 1949	Received from Pharmacy - 600,000 units				Lt. Veral Doe and		1,200,000 units	
27 May 1949	Audited & found Correct by				Capt. Joseph M. Starr, M.C.	Balance	1,200,000 units	

2. The penicillin register when not in use will remain under lock with the penicillin.

3. The same regulations apply to the safeguarding and auditing of penicillin as governs narcotics, in accordance with existing regulations. The following data will be incorporated on the top of each page of the penicillin register: a. Name of hospital. b. Strength of solution. c. All data to be complete with date, month, and year of each entry (figure not to be used for months). d. Name of patient in full. e. Amount of drug received from pharmacy. f. Time and amount administered in each dose. g. Total amount given each patient every twenty-four hours. h. Balance on hand at 2400 hours each day. i. Ordered by (name, rank of medical officer). j. Given by (name and rank of person administering drug).

4. Each supply received from pharmacy will be entered on an unused line. Name of medical officer requisitioning the penicillin from the pharmacy will be entered in the column "Ordered by;" signature of the person receiving the penicillin from the pharmacy will appear on the next unused line.

5. Each time the register is audited, the auditing officer will certify thereto by suitable entry and signature on next unused line.

6. All patients who are receiving penicillin therapy should have colored signal tables placed in their kardex unit during course of therapy. The administration of streptomycin should also be under the supervision of this team.

Summary: By establishment of a penicillin team in an Army hospital, the following is accomplished:

1. Conservation of the drug.
2. Assurance of proper administration and accurate dosage.

3. Proper recording of the drug.
4. Conservation of time, effort, and equipment.
5. Allows ward-duty personnel more time to care for the patients.

6. With the eight-hour-duty system in effect at hospitals in the Far East Command, the establishment of a penicillin and streptomycin team is considered highly important to increasing the efficiency of the nursing service.

- References:
1. Essentials of Nursing by Helen Young.
 2. The Art and Science of Nursing by Ella A. Rothweiler, MA, RN.
 3. TB MED 230, Chapter 2, paragraph 9.

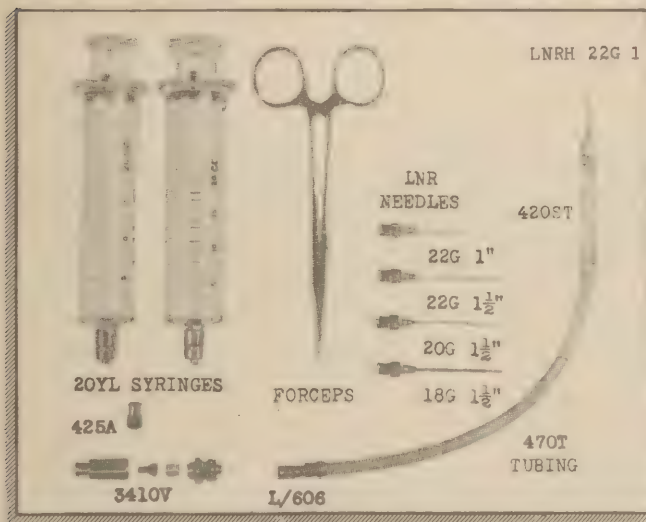
XXI. Pentothal Tray by Hazel J. Peterson, RN. EXTRACT FROM: The Journal of the American Association of Nurse Anesthetists - Volume XVII, February 1949, Number One.



Early in 1940 when I first began to use pentothal sodium, we had no special equipment available for its administration. In order for the anesthetist to observe the patient properly and carefully, it was necessary to have someone hold the syringe constantly and give the pentothal sodium as directed.

The Gilson one-way valve, manufactured by Becton, Dickinson & Company, came to my attention in 1941, and it has since proved a most satisfactory answer to my problem. It is a simple, compact, efficient, and inexpensive piece of equipment.

Our sets for administration of pentothal sodium are kept in 6 by 10 inch trays with covers, sterilized and ready for use. A tray contains the following equipment:



- 2 20 cc. Luer-Lok syringes
 - 1 Gilson valve set-up, with rubber tubing and observation glass and needle attached
 - 2 Needle caps
 - 1 18 mixing needle
 - 1 20 1 1/2 in. needle
 - 1 22 1 1/2 in. needle
 - 1 22 1 in. needle
- Preparation sponges and a forceps

The anesthetists clean and put up the sets for administration of pentothal sodium and therefore always know the needles are sharp and that everything is in good working order. Several sizes of needles are included in each set to give the individual anesthetist her preference. Personally, I prefer a 1 1/2 inch 22 Huber point needle.

We use a 2 1/2 per cent solution of pentothal sodium and keep several 20 cc. syringes of this solution available at all times. The tips of

the syringes are capped and may be kept for forty-eight hours or longer. Any pentothal sodium left over from a case is always saved, since the one-way valve prevents any contamination. This means considerable saving of solution.

The anesthetist who uses the one-way valve inserts the needle in a vein and fastens it in place with adhesive. She is then free to give full attention to taking blood pressure, supplementing the anesthetic with oxygen or gas, and keeping the records. The Gilson one-way valve permits no back flow of blood, and the needle may be kept open for several hours by frequent small additions of pentothal sodium. If the patient is getting fluids, the needle for giving pentothal sodium may be inserted into the intravenous tubing.

Our pentothal sodium equipment is inexpensive and easy to use. The rubber tubing or parts, such as the rubber valve, spring, or washers, may be replaced at a small cost.

XXII. Tetanus and Typhoid Immunization Procedure



Particular attention is invited to Change 10, AR 40-210, dated 23 May 1949, and to Change 1, TB MED 114, dated 26 May 1949. The procedures prescribed in these publications are immediately applicable in the Far East Command even though not covered specifically in FEC Circular 8, subject: "Immunization," dated 2 March 1948.

In these changes, the currently applied procedure for typhoid vaccination and revaccination is republished and a new policy for tetanus immunization is announced. The new procedure in tetanus immunization involves the administration of a stimulating dose of toxoid every four years following the last stimulating dose. It should be noted that the administration of a single dose of toxoid, approximately one year after the basic immunization and at the time of injury, is still required. It is considered that the four year interval prescribed may safely be approximated at forty-five to fifty-one months, thus allowing for the administration of the stimulating dose of toxoid at a time when one of the other routine immunizations is performed.

Change 1, TB MED 114 is reproduced below for the information and guidance of all medical officers.

TB MED 114
Change 1

DEPARTMENT OF THE ARMY TECHNICAL BULLETIN IMMUNIZATION

Department of the Army, Washington 25, D. C. 26 May 1949

TB Med 114, 28 February 1947, is changed as follows:

6. TYPHOID-PARATYPHOID VACCINE

* * * * *

b. Method of vaccination. (Superseded)

- (1) The initial vaccination consists of a subcutaneous injection of three 0.5 cubic centimeter doses of the triple vaccine administered at intervals of 7 to 28 days. In order to insure accuracy, a syringe of 6-cubic centimeter capacity or less will be used. Care will be taken to make the injections into the superficial subcutaneous tissue.
- (2) Revaccination of stimulating doses are accomplished by--
 - (a) The subcutaneous administration of 0.5 cubic centimeter of the triple vaccine annually.
 - (b) Intracutaneous administration of 0.1 cubic centimeter of the triple vaccine annually. This procedure may be used as an alternate if accomplished by a medical officer who is experienced in the technique of intracutaneous administration.

* * * * *

7. TETANUS TOXOID.

* * * * *

b. Method of immunization.

* * * * *

- (2) Routine stimulating dose. (Superseded) A single stimulating dose of 1 cc of tetanus toxoid is injected subcutaneously approximately 1 year after the initial series, every 4 years following the last stimulating dose, and as indicated in (3) below.

* * * * *

c. Alternate material and method of immunization. (Added) The following alternate material and method of immunization may be used as provided in paragraph 7d:

- (1) Material, tetanus toxoid, alum precipitated.

(2) Method of immunization:

- (a) Initial immunization. Initial immunization consists of two intramuscular injections of tetanus toxoid alum precipitated, $\frac{1}{2}$ cc each injection, at intervals of not less than 4 or more than 8 weeks.
- (b) Routine stimulating dose. A single stimulating dose of $\frac{1}{2}$ cc of tetanus toxoid alum precipitated is injected intramuscularly approximately 1 year after the initial series, every 4 years following the last stimulating dose, and as indicated in b(3) above.

d. Interim use of tetanus toxoid plain and alum precipitated. (Added)

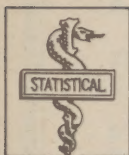
- (1) Alum precipitated tetanus toxoid will be substituted in the near future as a standard material for tetanus immunization. The plain and alum precipitated toxoids are equally effective in producing active immunization against tetanus. Alum precipitated tetanus toxoid will be used in order to have uniform immunization requirements for the Army, Navy, and Air Force. For purposes of economy, tetanus toxoid plain will be used until present stocks of this material are exhausted.
- (2) Personnel who have previously received the initial series of three injections of tetanus toxoid plain will not be given an initial series of two injections of tetanus toxoid alum precipitated. These individuals will be given stimulating doses as indicated using either 1 cc of the tetanus toxoid plain subcutaneously or $\frac{1}{2}$ cc of the tetanus toxoid alum precipitated intramuscularly when it becomes available.

(AG 300.5 (15 April 1949))

BY ORDER OF THE ACTING SECRETARY OF THE ARMY:

OMAR N. BRADLEY

Chief of Staff, United States Army

PART IIISTATISTICALEvacuation

Tabulated below are the number of patients evacuated from the major commands to the ZI during the five report weeks in April 1949:

	<u>BY AIR</u>	<u>BY WATER</u>	<u>TOTAL</u>
JAPAN	53*	252*	305*
MARBO	40	2	42
PHILCOM	15	4	19
RYCOM	35	17	52
FEC	143	275	418

*Includes 22 pnts who originated in Korea.

Tabulated below are the number of patients evacuated from the major commands to the ZI during the four report weeks in May 1949.

	<u>BY AIR</u>	<u>BY WATER</u>	<u>TOTAL</u>
JAPAN	21*	214*	235*
MARBO	21	4	25
PHILCOM	7	2	9
RYCOM	35	7	42
FEC	84	227	311

*Includes 20 pnts who originated in Korea.

During the nine report weeks in April and May, 180 patients were evacuated from Korea to Japan for further hospitalization and disposition or for onward evacuation to the ZI.

Evacuations of military personnel per thousand strength for April and May were as follows:

	<u>April</u>	<u>May</u>
JAPAN	2.6	1.9
KOREA	8.0	16
MARBO	2.2	1.3
PHILCOM	.94	.78
RYCOM	2.0	1.6
FEC	2.2	1.7

Hospitalization

The bed status as of 29 April 49 was as follows:

	<u>Total T/O</u>	<u>Total T/O</u>	<u>Total T/O</u>
	<u>Beds Authd</u>	<u>Beds Estab</u>	<u>Beds Occupied</u>
JAPAN	4,650	4,462	2,174
KOREA	300	100	71
MARBO	800	620	180
PHILCOM	1,525	1,520	1,112
RYCOM	750	443	290
FEC	8,025	7,145	3,827

The percent of T/O beds and established beds occupied as of 29 April 1949 was as follows:

The bed status as of 27 May 49 was as follows:

	<u>Total T/O</u>	<u>Total T/O</u>	<u>Total T/O</u>
	<u>Beds Authd</u>	<u>Beds Estab</u>	<u>Beds Occupied</u>
JAPAN	4,650	4,506	2,309
KOREA	300	100	12
MARBO	800	593	207
PHILCOM	1,275	1,270	1,107
RYCOM	750	443	303
FEC	7,775	6,912	3,938

The percent of T/O beds and established beds occupied as of 27 May 1949 was as follows:

RESTRICTED

	Percent Authorized T/O Beds Occupied	Percent of Etab Beds Occupied	Percent Authorized T/O Beds Occupied	Percent of Etab Beds Occupied
JAPAN	47	49	50	51
KOREA	24	71	4	12
MARBO	23	29	26	36
PHILCOM	73	73	87	87
RYCOM	39	65	40	68
FEC	48	54	51	57

Admission rates per 1000 troops per annum for April and May were as follows:

	FEC		JAPAN		KOREA		MARBO		PHILCOM		RYCOM	
	Apr	May	Apr	May	Apr	May	Apr	May	Apr	May	Apr	May
ALL CAUSES	604	584	687	641	803	678	259	282	588	714	413	449
DISEASE	554	522	636	575	747	583	210	237	520	642	379	409
INJURY	51	62	51	66	55	95	49	45	68	72	35	40
PSYCHIATRIC	11	13	11	12	29	13	9.6	15	9.2	12	5.0	16
COMMON RESPIR- ATORY DISEASE	89	49	125	62	68	69	34	20	30	40	3.5	0
INFLUENZA	.94	.85	1.0	.34	6.3	15	0	0	0	0	0	0
PRIMARY ATYPI- CAL PNEUMONIA	6.2	4.7	5.9	3.2	10	9.1	5.3	5.1	2.0	0	11	13
COMMON DIARRHEA	5.7	2.5	2.7	1.6	64	7.3	0	2.9	7.2	16	2.5	0
BACILLARY DYSENTERY	.82	.46	.46	.11	0	0	0	0	5.9	7.2	0	0
AMEBIC DYSENTERY	.71	.54	.19	.11	0	0	0	0	6.5	8.7	0	0
MALARIA, NEW	3.0	6.3	2.1	4.7	14	55	0	0	8.5	2.9	2.0	5.5
INFECTIOUS HEPATITIS	2.7	3.5	2.9	4.0	5.0	5.5	1.6	1.4	3.3	2.9	1.0	1.8
MYCOTIC DERMATOSES	4.1	5.1	5.9	7.4	0	0	1.6	1.4	.65	0	.50	0
RHEUMATIC FEVER	.65	1.3	.83	1.5	1.3	1.8	0	0	0	1.4	.50	1.2
VENEREAL DISEASE	143	176	166	202	204	204	20	28	71	99	165	190

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General Bethea Departs Far East Command

Major General JAMES A. BETHEA came to the Far East three years ago as the Chief Surgeon, United States Army Forces, Pacific. This month he leaves this command for his next assignment at Brooke General Hospital, Fort Sam Houston, Texas, where he plans to retire in October after service of thirty-three years in his career as military surgeon.

General Bethea was born at Marion, South Carolina, in 1887. His pre-medical studies were accomplished at Clemson College and his medical degree was awarded at Tulane University in 1913. After joining the Army Medical Corps in 1916 he attended and was graduated from the Army Medical School in 1917.

In his service as a U. S. Army Medical Officer throughout World War I, General Bethea advanced from the rank of first lieutenant to major. His war service in Europe included duty with the Fourth Division in France and as a member of the Army of Occupation in Germany. Returning to the United States in 1919, his tours of duty included Walter Reed General Hospital, Washington, D. C., and Letterman General Hospital, San Francisco, California, in addition to other posts throughout the United States. His overseas duty between wars also included tours at Panama and Philippine Islands. General Bethea is a Fellow of the American College of Surgeons and Diplomate of the American Board of Surgery, and is recognized as one of the top surgeons in the Army.

Early in World War II General Bethea assumed command of McCloskey General Hospital, Temple, Texas, after prior duty as Chief of Surgical Service at Fort Sam Houston. McCloskey General Hospital during World War II was known as one of the largest amputation and neuro-surgical centers in the United States. The peak load of the hospital came in August 1945 with 5,560 patients entered on the hospital roster. For his exemplary performance of hospital administration during the forty-three months at McCloskey, General Bethea was awarded the Legion of Merit.

In addition to technical planning and supervision of the vast program of adequate medical care for the sick and injured throughout the Far East General Bethea has at all times insisted on the application of modern techniques and procedures for the prevention of disease among military and other personnel of the command. Concurrently with the health programs in the Far East there has been continual planning and implementation of ways and means to improve and consolidate medical facilities. General Bethea has made every effort through personal estimates to bring about the maximum utilization of existing medical personnel and facilities for the troops and civilians of the command. The General has stressed and practiced full cooperation and coordination between the medical services of the Navy, Army and Air Force. This has resulted in a more economical utilization of critical medical specialists through joint use of facilities and/or reciprocal agreements.

At General Bethea's departure the Far East Command is bidding goodbye and Godspeed to an officer of outstanding medical technical knowledge and administrative ability.



The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor